EMS OFFICE USE ONLY
Received:
Issued:

APPLICATION FOR CERTIFICATION AS AN "OUTSIDE HOSPITAL"
EMERGENCY MEDICAL SERVICE

MEDEVAC SERVICE

1. SERVICE INFORMATION

Legal Name of Service: _____

Medicare Number: (Optional): _____

ADDRESS	
Mailing	All Geographic/Physical Locations

Head of Service: _____ JobTitle: _____

Telephone of Head of Service: Office:_____
Home:_____
Fax (Business): _____
e-mail contact: _____
Web site: _____
24-hour Dispatch number:_____ ☐ 911 ☐ E-911

2. CONTINUING AEROMEDICAL EDUCATION

Name of person(s) responsible for continuing aeromedical education program:

#	Name	Contact Telephone
1.		
2.		
3.		

3. PHYSICIAN MEDICAL DIRECTOR

List all physicians who are qualified under 7 AAC 26.630 and who agree to fulfill the responsibilities outlined in 7 AAC 26.610 - 7 AAC 26.690. (If your service has more than two physician medical directors, provide information for each.) If your physician medical director is affiliated with the Public Health Service or the military, please indicate state(s) of license and license number. The physician medical director(s) must sign below before the application is submitted.

By my signature below, I verify that I will fulfill the requirements in state regulations 7 AAC 26.610-7 AAC 26.690, including annual review of treatment protocols (standing orders). I further verify that the listed personnel have completed the aeromedical training as required in state regulations.

A. _____

Printed Name AK License # Signature

_____ Board Certified? Yes ☐ No ☐

Specialty Training Board Eligible? Yes ☐ No ☐

_____

Aeromedical Training Training Organization Date Completed

_____

Aeromedical Training Training Organization Date Completed

B. _____

Printed Name AK License # Signature

_____ Board Certified? Yes ☐ No ☐

Specialty Training Board Eligible? Yes ☐ No ☐

_____

Aeromedical Training Training Organization Date Completed

_____

Aeromedical Training Training Organization Date Completed

C. Date physician-signed standing orders were last: _____ _____

by physician. Reviewed Revised

4. INFLIGHT PATIENT CARE FORM

If you do not have an EMS report form which meets state requirements, the Alaska Air Medical Transport Form (#06-1466) may be obtained from the EMS Unit at P.O. Box 110616, Juneau, AK 99811-0616. Check the appropriate box regarding your EMS inflight Patient Care Report Form:

☐ Enclosed Own Report Form ☐ Service uses Alaska Air Medical Transport Form

Send me _____ Alaska Air Medical Transport Forms.

5. CERTIFIED/LICENSED PERSONNEL

List all certified and licensed personnel, such as Emergency Medical Technicians (EMT) I, II, and III, Mobile Intensive Care Paramedics, Physician's Assistants, Nurse Practitioners, Registered Nurses, or Physicians involved in the transportation and care of patients. Include name, certificate/license number, status, and medevac training status. Regulations require 16 hours, per certification period, of continuing medical education (CME) in specialized aeromedical patient transportation topics.

Name	Level of Certificate/ License	State Certificate/ License & Number[1]	Expiration Date	Date of Initial Aeromedical Training[2]	# Hours of Aeromedical Training in Last 2 Years & Dates of Training [2]

[1] If the air ambulance service is not based in Alaska, please list the state of licensure and license numbers.

[2] This refers to department-approved training in accordance with 7 AAC 26.330 (c)(3).

6. INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT

A. The following is a list of the appropriate equipment necessary for medevac services to perform BLS and ALS medical procedures within the skill levels of available certified personnel. Please verify with a check mark that your service has the following equipment and will carry it on the aircraft, when appropriate:

Basic Life Support (BLS) EQUIPMENT/SUPPLIES

VENTILATION AND AIRWAY EQUIPMENT:

- ☐ Oxygen system to provide 8 liters per minute flow for the longest anticipated medevac flight plus 45 minutes
- ☐ Portable oxygen tank with regulator
- ☐ Adult bag-valve-mask with reservoir and mask
- ☐ Pediatric bag-valve-mask with reservoir and pediatric mask
- ☐ Infant bag-valve-mask with reservoir and infant mask
- ☐ Oxygen connection tubing
- ☐ Non-rebreathing masks, adult and pediatric sizes
- ☐ Oxygen masks, infant
- ☐ Oxygen cannulas, adult and pediatric
- ☐ Portable suction unit
- ☐ Suction catheters (6F-14F)
- ☐ Rigid suction tip (e.g., Yankaur)
- ☐ Pediatric bulb syringe
- ☐ Suction rinsing water bottle
- ☐ Oropharyngeal airways (00-5), adult, pediatric, and infant
- ☐ Nasopharyngeal airways, sizes 18F-34F or 4.5 - 8.5 mm
- ☐ Water-soluable lubricant

IMMOBILIZATION EQUIPMENT:

- ☐ Stretcher, main - with appropriate patient restraining device
- ☐ Cervical collars, adult and pediatric
- ☐ Cervical immobilization device, adult and pediatric (sandbags may not be used)
- ☐ Long spine board
- ☐ Short backboard, KED, or equivalent
- ☐ Traction splint, adult and pediatric
- ☐ Extremity splints, adult and pediatric (e.g. vacuum, air, padded board, etc.)
- ☐ Infant car seat (desirable but not required)
- ☐ Restraints, patient

BANDAGING EQUIPMENT:

- ☐ Universal dressings or trauma dressings
- ☐ 4 x 4 gauze pad packs
- ☐ Roller bandages (eg., Kerlex or Kling type)
- ☐ Adhesive tape, various sizes
- ☐ Burn sheets, sterile
- ☐ Triangular bandages with safety pins
- ☐ Trauma shears
- ☐ Occlusive dressings

6. INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT – continued

OBSTETRICAL:

- ☐ Obstetrical kit, sterile
- ☐ Thermal blanket (to help newborn maintain body heat)

MISCELLANEOUS:

- ☐ Blood pressure cuff, adult, pediatric and infant; in addition, large adult size recommended
- ☐ Stethoscope
- ☐ Activated charcoal, 25-50 grams
- ☐ Substance high in sugar for treatment of diabetic patients
- ☐ Glasgow Coma Scale reference
- ☐ Pediatric Trauma Score reference
- ☐ Emesis basin, urinal, bed pan
- ☐ Blankets
- ☐ Sheets
- ☐ Pillows
- ☐ Sterile saline for irrigation
- ☐ Small stuffed toy (desirable but not required)

SAFETY:

- ☐ Fire extinguisher appropriate to aircraft
- ☐ Flashlight
- ☐ Body fluid isolation devices and supplies (gloves, masks, gowns, eye protectors)

Other EMT-I medications/equipment carried:

- ☐ _____
- ☐ _____
- ☐ _____

Advanced Life Support (ALS) EQUIPMENT/SUPPLIES

EMT-II EQUIPMENT/SUPPLIES:

- ☐ Advanced Airway Device (Type: _____) & administration equipment
- ☐ Naloxone HCI
- ☐ 50% Dextrose in Water
- ☐ Balanced Salt Solution (e.g., normal saline)
- ☐ Syringes of various sizes
- ☐ Needles of various sizes
- ☐ Three-way Stopcocks (desirable but not required)
- ☐ Tubes for Blood Samples
- ☐ Pediatric Medication Dosage Chart
- ☐ IV Catheters (14-24 Gauge)
- ☐ Intraosseous Needles
- ☐ Mini (60 gtts/cc) and Maxi (10, 12, or 15 gtts/cc) IV Sets

Other EMT-II medications carried:

- ☐ _____
- ☐ _____
- ☐ _____

6. INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT – continued

EMT-III EQUIPMENT/SUPPLIES:

- ☐ Monitor/Defibrillator
- ☐ Pediatric paddles/patches for defibrillator
- ☐ Monitoring electrodes - adult and pediatric sizes
- ☐ Defibrillator Gel/Pads
- ☐ Lidocaine 1% or 2%
- ☐ Lidocaine 20% or pre-mixed bag for drip
- ☐ Morphine Sulphate
- ☐ Epinephrine 1:1,000
- ☐ Epinephrine 1:10,000
- ☐ Atropine

Other EMT-III medications carried:

- ☐ _____
- ☐ _____
- ☐ _____

PARAMEDIC EQUIPMENT/SUPPLIES: (Please indicate which paramedic medications you carry)

- ☐ Adenosine
- ☐ Albuterol
- ☐ Adenosine
- ☐ Albuterol
- ☐ Aminophylline
- ☐ Amiodarone
- ☐ Diazepam
- ☐ Diphenhydramine
- ☐ Dopamine
- ☐ Furosemide
- ☐ Glucagon
- ☐ Metoprolol
- ☐ Midazolam
- ☐ Phenytoin
- ☐ Propanolol
- ☐ Thiamine
- ☐ Laryngoscope with blades, adult and pediatric sizes
- ☐ ET Tubes (uncuffed sizes 2.5 - 6.0; cuffed sizes 6.0 - 8.0)
- ☐ End tidal CO_2 detection device
- ☐ Magill Forceps – adult and pediatric sizes
- ☐ ET tube stylet - adult and pediatric sizes

Other MICP medications carried:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

6. INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT – continued

OPTIONAL EQUIPMENT/SUPPLIES used by your service:

- ☐ Blood glucose monitoring system
- ☐ Automated external defibrillator
- ☐ Nebulizer system
- ☐ Nasogastric tubes

Please list other optional equipment or supplies you carry which you wish to have listed in your records:

B. Do you have sufficient equipment and medications to provide advanced life support procedures which are outlined in the standing orders signed by your physician medical director? YES ☐ NO ☐

C. Specify equipment needed or missing and your plans to obtain it:

D. Has all equipment been tested in the airborne environment to ensure that it works as designed at high altitudes and does not interfere with the operations of any aircraft in which it will be used? YES ☐ NO ☐

7. AIRCRAFT INFORMATION FOR PATIENT TRANSPORTS

A. Does the Service have aircraft available 24 hours a day, 7 days a week, to provide patient transport, except when flying conditions are unsafe or the members of the service are responding to another emergency? YES ☐ NO ☐

B. Does the Service own the aircraft used for transporting patients? YES ☐ *NO ☐

*If "NO", list below the air carrier(s) with whom the Service has written agreement(s) in order to provide available transport 24 hours a day, 7 days a week, and attach copies of agreements with this application. If there are more than two air carrier written agreements, submit information for each.

WRITTEN AGREEMENTS WITH AIR CARRIERS

_____	_____
Legal Name of Air Carrier	Legal Name of Air Carrier
_____	_____
Mailing Address	Mailing Address
_____	_____
City State Zip Code	City State Zip Code
_____	_____
Name of Agency Head	Name of Agency Head
_____	_____
Business Phone of Agency Head	Business Phone of Agency Head
_____	_____
Agreement Starting/Ending Date	Agreement Starting/Ending Date

Please list below the type of aircraft either owned by the organization or expected to be used through written agreement(s) and answer if each aircraft has proper restraining devices and litters. Use additional paper if necessary.

AIRCRAFT TYPE			RESTRAINING DEVICES	LITTERS
MAKE	MODEL	YEAR	YES/NO	YES/NO
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9				

8. AFFIRMATION

I hereby affirm that _____(Name of Service) will comply with all rules and regulations of the Department of Health & Social Services 7 AAC 26.310 –7 AAC 26.400, including:

a) To provide basic life support, having a certified EMT-I, who has had department-approved medevac training, to accompany each medevac patient; or to provide advanced life support, having a certified EMT-II or III, Mobile Intensive Care Paramedic, or other licensed medical personnel such as a Nurse Practitioner, Registered Nurse, Certified Emergency Nurse, Critical Care Emergency Nurse, Physician's Assistant, or Physician, who has had department-approved medevac training, to accompany each medevac patient;

b) To provide a continuing medical education program in medevac training that will enable certified or licensed emergency medical personnel to meet state recertification requirements in specialized aeromedical patient transport topics;

c) To ensure the completion of an approved inflight patient care form for each patient treated. The form must document vital signs and medical treatment given the patient. A copy of the completed inflight patient care form must
   1) accompany the patient to the treatment facility;
   2) be sent to the physician medical director; and
   3) be kept by the medevac service as a permanent record for five years.

d) If advertising, to list in any advertisements the levels of certified or licensed medical personnel for its service.

_____
Printed Name of Head of Service

Title:_____

Signature:_____

Date:_____

9. NOTARIZED STATEMENT

In the presence of a notary public, postmaster, clerk of court, judge, magistrate, state trooper, or authorized state employee, if such official is available, applicant must sign here. **I certify under penalty of perjury that the foregoing is true and accurate.**

_____ _____
Signature of Applicant Date

THIS IS TO CERTIFY that on this ___ day of _____, 200__, before me appeared _____ to me known and known to me to be the person named in and who executed the foregoing instrument and acknowledged voluntarily signing and sealing the same.

_____
Notary Public, Postmaster, Clerk of Court, Judge, Magistrate, State Trooper, or authorized State employee

My Commission Expires: _____
My Badge Number is _____